Nagasaki University of Foreign Studies - JASIN Program

Health Form　健康診断書

Name: _____ ☐ Male ☐ Female　Date of Birth: _____

To be filled out by the student:

1. Do you have any health conditions the university or your accommodation should know about?
   ☐ Yes ☐ No　If so, please explain in detail :

   ※In order to provide a safe study abroad environment, it is important that you note **all** medical conditions.

2. Are you taking any medication?　☐ Yes ☐ No
   If so, please list medications and describe in detail the condition it is treating:

3. Allergies: Please describe in detail:

   Please use the back of this form if you need more space.

To be filled out by a medical practitioner

1. (height)　cm　(weight)　kg
   (eyesight)
   (without spectacles)　(with spectacles)
   (left)　／
   (right)　／
   (hearing)
   (left)
   (right)
   (color-perception)
   ☐ (normal)
   ☐ (abnormal)

2. History of special medical conditions, allergies, or physical disabilities.
   ☐ No
   ☐ Yes　→　☐ Medical conditions　☐ Physical disabilities
   ☐ Mental illnesses
   (eg. ADHD, depression, autism, or other intellectual disabilities, etc.)
   ☐ Allergies
   (eg. pets, medication, stinging insects, house dust, etc.)

   Please describe.

3. Present prescription(s): (Please write in generic name; name of products may differ among countries)

4. Please check the box if there is any irregularity.
   ☐ Tonsils, nose or throat　☐ Heart or blood vessels
   ☐ Stomach or digestive syster　☐ Genito-urinary system
   ☐ Brain or nervous system　☐ Blood or endocrine system
   ☐ Lungs or respiratory　☐ Bones or joints
   ☐ Other abdominal organs　☐ Skin

   Comments

5. Tuberculosis Examination
   ☐ Normal
   ☐ To be rechecked
   ☐ Requires treatment

   (Further Remarks)

6. I diagnose that the applicant's health condition is:
   ☐Excellent　☐Good　☐Fair　☐Poor
7. Do you think the applicant's condition is good enough for him/her to study in Japan?
   ☐Yes　☐No

8. Other remarks

I hereby certify the above diagnosis.

Physician's signature: _____　Physician's name: _____

Physician's address: _____　Date: _____